

10876

Reg. Dist.

No. 185

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARGIN RESERVED FOR BONDING

1. PLACE OF DEATH: COUNTY Harford			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Harford		
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Havre de Grace		LENGTH OF STAY (in this place) D.O.H.	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bel Air Rural.		(If rural, give location) Harford Terrace.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 99 Harford Memorial Hospital			STREET ADDRESS		
3. NAME OF DECEASED: (Type or Print)	(First) HERMAN	(Middle) EUGENE	(Last) ADAMS	4. DATE OF DEATH 11/25	(Month) (Day) (Year) 11 25 55
5. SEX: Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Dec 5th 1921	9. AGE last birthday: 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY: Gravel Industry	11. BIRTHPLACE (State or foreign country): West Virginia	12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: Wester Adams.			14. MOTHER'S MAIDEN NAME: Zollie Higgins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 215-16-6331	17. INFORMANT & ADDRESS: Mrs Herman & Adams Bel Air Rural 1-200.		
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1 Immediate cause Myocardial infarct (a) DUE TO coronary occlusion Antecedent cause(s) Diseases or conditions, if any, (b). giving rise to the above cause DUE TO stating underlying cause last (c)					
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) Bel Air	(County) Harford	(State) MD
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at M. work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE <i>William Harford</i>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Nov 26th 1955	NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens	LOCATION (City, town, or county) Bel Air Harford Co. MD	(State)	
DATE REC'D BY LOCAL REG. Nov. 26-55	REGISTRAR'S SIGNATURE G. D. Lewis M. D.	24. FUNERAL DIRECTOR ADDRESS John G. Kerring Aberdeen Rd.			

BUREAU V. S

NOV 28 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10877

## 1087 CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY TOWN STREET ADDRESS (If rural give location)	
24 Harde-Grace D.o.a				Maryland		Aberdeen, x Rural Delivery.	
99 Harford Memorial Hospital							
<b>3. NAME OF DECEASED</b> (First) Maude (Middle) (Last) Atkins				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) 11 4 1955			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Child.	8. DATE OF BIRTH 7/8/50	9. AGE last birthday 5	10. IF UNDER 1 YEAR yrs. Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter Atkins				14. MOTHER'S MAIDEN NAME Viola Johnson Viola Atkins, (Mother)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS Viola Atkins, (Mother)							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
571.1 IMMEDIATE CAUSE (A) Self sufflating heart ANTECEDENT CAUSE(S) DUE TO (B) Cerebral hemorrhage-Enteritis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Enteritis							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from 11/4/55, 1955, to 11/4/55, 1955, that I last saw the deceased alive on 11/4/55, 1955, and that death occurred at 6 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Sam W. Herbert M.D.</i> M.D. <b>ADDRESS</b> (Street, city, town, state) <i>Hanover Grace Md - 11/6/55</i> <b>DATE SIGNED</b> <i>11/6/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-9-55		NAME OF CEMETERY OR CREMATORIUM Union Methodist		LOCATION (City, town, or county) Aberdeen, Md	
24. REC'D BY REGISTRAR DATE Nov. 9-1955		REGISTRAR'S SIGNATURE A. L. Lewis M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Bullock Hanover Grace		ADDRESS	

REAU-V.

## 10896 CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

COUNTY HARFORD

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN RURAL-DARLINGTON

LENGTH OF STAY  
(in this place)

2 yrs.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY HARFORD

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN

RURAL-DARLINGTON

STREET  
ADDRESS

(If rural give location)

U.S. ROUTE #1

3. NAME OF  
DECEASED:  
(Type or Print)

(First) ALBERT HERVEY ASHTON

(Middle)

(Last)

4. DATE (Month) (Day) (Year)

NOV. 12, 1955

5. SEX: M

6. COLOR OR  
RACE: W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): MARRIED

8. DATE OF BIRTH: MAR. 11, 1883

9. AGE last birthday 72

IF UNDER 1 YEAR  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): FARMER10B. KIND OF BUSINESS  
OR INDUSTRY: AGRI.

11. BIRTHPLACE (State or foreign country): COLUMBUS, OHIO

12. CITIZEN OF WHAT  
COUNTRY? U.S.A.

13. FATHER'S NAME:

RICHARD ASHTON

14. MOTHER'S MAIDEN NAME:

ELIZA Mc GREW

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

16. SOCIAL SECURITY NO. 219-07-2514

3 No

17. INFORMANT &amp; ADDRESS:

NINA R. ASHTON, DARLINGTON, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.1

IMMEDIATE CAUSE

(A)  
DUE TO

Acute Congestive Heart Failure

INTERVAL BETWEEN  
ONSET AND DEATH  
united

ANTECEDENT CAUSE (S)

(B)  
DUE TODISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH, BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

A Leukemic Leukemia

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 1, 1955, to Nov. 12, 1955, that I last saw the deceased  
alive on Nov. 11, 1955, and that death occurred at 1145 P.M. from the causes and on the date stated above.  
SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

BURIAL

Nov. 16, 1955

DARLINGTON

DARLINGTON, MD.

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

11-16-55

Bessie L. Fowles

JOHN H. HARKINS, DELTA, PA.

BUREAU V. S.

NOV 18 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C \$5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10874 CERTIFICATE OF DEATH

10879

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Edgewood (If rural give location)			
24 HARFORD HAURE de GRACE	19 days	24 HARFORD Edgewood	1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	11 HARFORD Memorial Hosp. Box 177					
3. NAME OF DECEASED (Type or Print)	4. DATE OF DEATH		(Month) (Day) (Year)			
ALBERT ALBDEBERT LeRoy	(Middle) widowed	(Last) April 11 1897	11 31 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	white	widowed	11-1897	58 yrs.	Months Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TRACT Foreman Penn Railroad		Penn	Penn		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
John Bair		Mary Dowland				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
No		464-717-07-5430		John T. Bair, Edgewood R.D. Maryland.		
18. MEDICAL CERTIFICATION						
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
420.1 IMMEDIATE CAUSE (A) Coronary occlusion with myocardial infarction - posterior 2 days.						
ANTECEDENT CAUSE(S) DUE TO						
DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO						
(C) Arteriosclerotic Cardiovascular disease several yrs.						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						
Chronic bronchitis and Upper Respiratory Infection not certain						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Nov. 9th, 1955, to Nov. 27th, 1955, that I last saw the deceased alive on Nov. 27th, 1955, and that death occurred at 3:12 AM, from the causes and on the date stated above. SIGNATURE						
ADDRESS (Street, city, town, state)						
DATE SIGNED						
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		LOCATION (City, town, or county)	
Burial		Nov. 29, 1955	Bel Air Memorial Gardens		Bel Air, Harford, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Nov. 28-55		A. A. Lewis m. d.	Howard K. McComas & Son, Abingdon, Md.		Howard K. McComas Jr.	

BY AUTHORITY OF THE STATE-DEPARTMENT

THE GOVERNMENT OF THE  
UNITED STATES OF AMERICA

TO THE ATTENTION OF

THE ATTORNEY GENERAL OF THE UNITED STATES

RECEIVED  
NOV 29 1955

BUREAU V. S.

NOV 29 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10897 CERTIFICATE OF DEATH

10880

182

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Harford</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Harford</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Bel Air, Rural</b>	LENGTH OF STAY (in this place) <b>2 wks.,</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood, Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Harford Convalescing Home</b>		STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (First) <b>George</b> (Middle) <b>Frederick</b> (Last) <b>Bangelsdorf</b>		4. DATE (Month) (Day) (Year) <b>Nov. 15, 1955</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 17, 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home construction</b>	9. AGE last birthday <b>77</b> yrs.
13. FATHER'S NAME <b>Charles Bangelsdorf</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co., Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-16-9741</b>	
17. INFORMANT & ADDRESS <b>Harry Bangelsdorf, Edgewood, Md.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>443</b> IMMEDIATE CAUSE (A) <b>CEREBRAL HEMORRHAGE (Massive)</b>		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <b>Chr. Hypertensive Cardio-Vascular Disease</b>			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <b>M.D. Forest Hill, Md.</b>		(County) <b>Forest Hill</b> (State) <b>Md.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov. 8, 1955</b> , to <b>Nov. 15, 1955</b> , that I last saw the deceased alive on <b>Nov. 15, 1955</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city, town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>11/17/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>11/17/55</b> NAME OF CEMETERY OR CREMATORIAL <b>Trinity Lutheran</b> LOCATION (City, town, or county) <b>Joppa, Harford, Md.</b>	
24. REC'D BY REGISTRAR <b>Priscilla Lowood</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son, Abingdon, Md.</b> ADDRESS <b>Harford Convalescing Home</b>	
DATE <b>11-17-55</b>			



## 10898 CERTIFICATE OF DEATH

Reg. Dist. No 182

## 1. PLACE OF DEATH:

COUNTY Harford MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town)  
 TOWN Farm Shore Pa R.D.  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS  
 00

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Harford  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Rural  
 STREET  
 ADDRESS Farm Shore Pa R.D.

3. NAME OF  
DECEASED:  
(First)  
(Type or Print)Nannie Barton

4. DATE  
(Month) (Day) (Year)  
 OF  
 DEATH: Nov 19 1955

## 5. SEX:

FemaleWhiteSINGLE, MARRIED,WIDOWED, DIVORCED(Specify):

## 8. DATE OF BIRTH:

Single Feb 24, 1881

## 9. AGE last birthday:

74yrs.10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired): Housewife10b. KIND OF BUSINESS OR  
INDUSTRY: Housekeeping11. BIRTHPLACE (State or foreign country): Harford Co Md12. CITIZEN OF WHAT  
COUNTRY?: U.S.A.

## 13. FATHER'S NAME:

Joshua Barton

## 14. MOTHER'S MAIDEN NAME:

Sarah Ann Jones15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:Leonie Boston Baltimore MdInterval Between  
Onset And Death

40 days

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X  
Immediate cause(a) Due toCerebral HemorrhageAntecedent causes (s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.(b) Due toarteria sclerosis

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes  No 

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 18 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10875 CERTIFICATE OF DEATH

10881

Reg. Dist. No. 152

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN 32 32		MARYLAND LENGTH OF STAY (In this place) 24 yrs.		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel-Air Bel-Air 32		STREET ADDRESS (If rural give location) 203 Archer Street 203 Archer Street	
3. NAME OF DECEASED (First) MOLLIE (Middle) E. BOND (Last)				4. DATE (Month) OF DEATH NOV., 23 (Day) (Year) 1955			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 10-31-1869	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Harford Co. Maryland			
13. FATHER'S NAME James D. Preston				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. —			
17. INFORMANT & ADDRESS Mrs. Rose Young - Bel-Air, Md				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 18 mos.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X IMMEDIATE CAUSE (A) METASTATIC CARCINOMA OF LUNGS				19. MAJOR FINDINGS OF OPERATION Scirrhous Carcinoma breast (simple amputation)			
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO (B) CARCINOMA OF RT. BREAST (primary site) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION June 1952		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		(State)	
22. I hereby certify that I attended the deceased from Jan 1952, 19....., to Nov. 23, 1955, that I last saw the deceased alive on Nov. 23, 1955, and that death occurred at 5:30 PM, from the causes and on the date stated above. SIGNATURE <i>Willard F. Hudson</i> ADDRESS (Street, city, town, state) <i>M. D. Forest Hill, Md.</i> DATE SIGNED <i>11-26-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-27-55		NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		LOCATION (City, town, or county) Fairview, Md.	
24. REC'D BY REGISTRAR DATE 11-26-55		REGISTRAR'S SIGNATURE Musicala Lowood		25. FUNERAL DIRECTOR'S SIGNATURE Olein J. Bullock, Hause Gray		ADDRESS	

DO NOT TURN THIS PAGE TO REACH THE STATION STATE

1823

RECEIVED TO STATION STATE

BUREAU V. S

NOV 28 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15c-155 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10876 CERTIFICATE OF DEATH

10882

Reg. Dist. No. 185-

Item 12, Film G190 12-13-55 e.t

## 1. PLACE OF DEATH

COUNTY Han Ford  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)

TOWN 24 Harre-de-Grace LENGTH OF STAY  
 (in this place)  
 4 months

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 71 Han Ford Memorial Hospital

## MARYLAND

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland, COUNTY Cecil

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Port Deposit STREET ADDRESS  
 (If rural give location)  
Old Mill 07X-2

## 3. NAME OF DECEASED

(First) (Middle) (Last)  
 (Type or Print)Patsy Pasquale Bosco4. DATE (Month) (Day) (Year)  
 OF DEATH 11-26 19555. SEX Male6. COLOR OR RACE white10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired) Retired10b. KIND OF BUSINESS  
 OR INDUSTRY Retired

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Hospital records

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

Italy

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

141X IMMEDIATE CAUSE (A) Cancer tongue & hydratosis

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. DUE TO

(C)

INTERVAL BETWEEN  
 ONSET AND DEATH3 yrs.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
 While  Not while  
 at work  at work 

21f. HOW DID INJURY OCCUR?

M. N. S. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO. PP. QQ. RR. TT. UU. VV. WW. XX. YY. ZZ. AA. BB. CC. DD. EE. FF. GG. HH. II. JJ. NN. OO.

8820

RECEIPT CERTIFICATE OF DEATH

RECEIVED - STATE DEPARTMENT OF FINANCIAL INSTITUTIONS

BUREAU V. S.  
RECEIVED  
DEC 1 1955

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10883

## 10899 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY HARFORD (If rural give location)
HARFORD RURAL HARFORD DE GRACE	LIFE	MD. RURAL HARFORD DE GRACE	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS HOME		STREET ADDRESS HOME	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH Nov. 25, 1955	
(First) ALEXANDER THEODORE (Middle) (Last) BRADFORD			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH AUG. 9, 1882
9. AGE last birthday 73 yrs.	10. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Geo. W. BRADFORD	14. MOTHER'S MAIDEN NAME Rose FRENCH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS MRS. DEBORAH B. BRADFORD	
18. MEDICAL CERTIFICATION HOME INTERVAL BETWEEN ONSET AND DEATH 10/22			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 181X IMMEDIATE CAUSE (A) <u>Carcinoma</u> 8 Bladder ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 1, 1955</u> , to <u>Nov. 25, 1955</u> , that I last saw the deceased alive on <u>Nov. 23, 1955</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Dreday Phillip</u> M.D. ADDRESS (Street, city, town, state) <u>DeLayton Ind</u> DATE SIGNED <u>11/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 28, 1955	NAME OF CEMETERY OR CREMATORIAL WESLEYAN CHAPEL HARFORD
24. REC'D BY REGISTRAR DATE Nov. 28.		REGISTRAR'S SIGNATURE Bertha B. Knight	25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, HARFORD DE GRACE
		ADDRESS MD.	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10877

10884

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford 31 aberdeen	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Washington Street 00	—	STREET ADDRESS aberdeen. (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)	Minnie Levina Brown	4. DATE OF DEATH Nov 6th 1955	(Month) (Day) (Year)			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 5th 1886	9. AGE last birthday 69 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Home.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel G. Brown Sr.		14. MOTHER'S MADDEN NAME Levina Gilbert				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Edua Rain, 607 Jersey Ave. aberdeen, N.J.		
18. MEDICAL CERTIFICATION 442 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Nephrosclerosis						
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive Heart Disease						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from ..... 1948, to ..... 11-6-1955, that I last saw the deceased alive on ..... 11-5-1955, and that death occurred at ..... M, from the causes and on the date stated above. SIGNATURE <i>Peter F. Robinson</i> M.D.						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 9th.		NAME OF CEMETERY OR CREMATORIAL Union M. & S. Cemetery		LOCATION (City, town, or county) aberdeen Rural, N.J.
24. REC'D BY REGISTRAR DATE Nov. 9-55		REGISTRAR'S SIGNATURE Mellie G. Perry		25. FUNERAL DIRECTOR'S SIGNATURE John G. Barrington		ADDRESS aberdeen N.J.

DEPARTMENT OF JUSTICE - NATIONAL SECURITY DIVISION

REGISTRATION  
OF  
MAILING ADDRESS

REGISTRATION OF MAILING ADDRESS

REGISTRATION

U. S. BUREAU

NOV 14 1965

RECEIVED

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Cecil Maryland	STATE Pa.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	
TOWN 1/2 mi. north Port Deposit D.O.A.		CITY (If outside corporate limits write RURAL and give nearest town) OR	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		TOWN Philadelphia	
Webster's Tavern		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		(First) CLAUDE	(Middle) ROOSEVELT
		(Last) BRYANT	4. DATE OF DEATH 11 29 19 55
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 12/18/05
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: Unknown	9. AGE last birthday: 50 yrs.
		11. BIRTHPLACE (State or foreign country): St. Marys Co. Md.	12. CITIZEN OF WHIC COUNTRY? USA
13. FATHER'S NAME: Wm. C. Bryant		14. MOTHER'S MAIDEN NAME: Anna Henry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO.: Unknown	
		17. INFORMANT & ADDRESS: Wm. C. Bryant 2443 1/2 Offord St. Pa. Pa.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 982X Immediate cause (a) Stab wound of heart.			
Antecedent cause(s) (b) Massive pericardial hemorrhage Diseases or conditions, if any, (c) giving rise to the above cause DUE TO stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 11/29/55		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		(State)	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Tavern	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 11/29/55 9:15 PM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? altercation.		Stabbed with ice pick during	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE: William J. Lewis			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF 11/30/55 NAME OF CEMETERY OR CREMATORIUM Unknown	
DATE REC'D BY LOCAL REG. NO. 30-55		REGISTRAR'S SIGNATURE G. L. Lewis M. D.	
24. FUNERAL DIRECTOR: James E. Dury 2121 1/2 Offord St. Phila. Pa.		LOCATION (City, town, or county) Philadelphia Pa. (State) ADDRESS	

BUREAU V. S

DEC 2 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10879 CERTIFICATE OF DEATH

10886

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY TOWN STREET ADDRESS
24 HARFORD HAURE DE GRACE	LENGTH OF STAY (in this place) 30 yrs.	MO. HAURE DE GRACE	HARFORD HAURE DE GRACE 24 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 JUNITA, ST.			
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH Nov. 23 1955	
ALBERT		CARPENTER	
5. SEX MALE	6. COLOR OR RACE BLACK	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEB. 27, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MASS.	9. AGE last birthday 75 yrs.
13. FATHER'S NAME Wm.	14. MOTHER'S MAIDEN NAME Wm.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 219-07-2584	17. INFORMANT & ADDRESS ELsie May Carpenter	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Pulmonary Embolus - ANTECEDENT CAUSE(S) DUE TO Primary Occlusion - DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Hypertension & Hypertrophy - (C) Atherosclerosis or Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, term, factory, OF INJURY street, office bldg., etc.)	21c. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. ADDRESS (Street, city, town, state)	
22. I hereby certify that I attended the deceased from September 4, 1955, to November 23, 1955, that I last saw the deceased alive on November 23, 1955, and that death occurred at 4:30 A.M., from the causes and on the date stated above. SIGNATURE <i>John W. Walker, M.D.</i> DATE SIGNED <i>Nov. 23, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF Nov. 26 '55	NAME OF CEMETERY OR Crematory SKINNER'S CEM. HAVRE DE GRACE, MD.	LOCATION (City, town, or county) (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE R. Madeline Mitchell	ADDRESS NO. 10886
DATE Nov. 26-1955	L. Lewis m.d.	H. Lewis m.d.	

## HAWAII POLICE DEPARTMENT

951514-1955 NOV 28 1955

HAWAII POLICE

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HAWAII

SUSP.

21-05-5284 FELICE WAKA (KIRPENBERG)

951514-1955 NOV 28 1955

HAWAII POLICE

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NOV 28 1955

HAWAII POLICE

## INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10887

## 10900 CERTIFICATE OF DEATH

Reg. Dist. No. 180

## 1. PLACE OF DEATH

COUNTY **Harford**  
 CITY (If outside corporate limits, write RURAL  
OR end give nearest town)  
 TOWN **Bel Air R.D.**

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS  
**00**

MARYLAND  
 LENGTH OF STAY  
 (In this place)  
**lifetime**

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Harford**  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Bel Air R.D.**

STREET  
ADDRESS  
**Creswell**

3. NAME OF  
DECEASED  
(Type or Print)**Roland****W.****Cullum**

4. DATE (Month) (Day) (Year)

**Nov. 29 1955**

## 5. SEX

6. COLOR OR  
RACE  
**male white**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) **single**8. DATE OF BIRTH  
**Dec. 7, 1936**9. AGE last birthday  
**18**  
yrs.IF UNDER 1 YEAR  
Months Dey Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) **none**10b. KIND OF BUSINESS  
OR INDUSTRY  
**none**11. BIRTHPLACE (State or foreign country)  
**Maryland**12. CITIZEN OF WHAT  
COUNTRY?  
**U.S.A.**

## 13. FATHER'S NAME

**James W. Cullum**

## 14. MOTHER'S MAIDEN NAME

**Edna M. Elliott**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) **no** (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

**none**

## 17. INFORMANT &amp; ADDRESS

**James W. Cullum, Bel Air, R.D. 2 Md**

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**501X** IMMEDIATE CAUSE

(A)

*Spastic Paraplegia - idiocy*INTERVAL BETWEEN  
ONSET AND DEATH**19 yrs**

ANTECEDENT CAUSE(S) DUE TO

(B)

*Asbestosis - bronchitis*DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST, DUE TO

(C)

**10 days**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.*ascaris infestation anemia***years**

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While  Not while   
at work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 17, 1955**, to **Nov. 29, 1955**, that I last saw the deceased  
alive on **Nov. 27, 1955**, and that death occurred at **4A.M.** from the causes and on the date stated above.

## SIGNATURE

*Med. W. Hodous*

ADDRESS (Street, city, town, state)

DATE SIGNED

**11-29-55**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)**Burial**

## DATE THEREOF

**Dec. 2, 1955**

## NAME OF CEMETERY OR CREMATORIAL

**Calvary Methodist**

## LOCATION (City, town, or county)

(State)

**Calvary, Harford, Md.**

24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

**Norma G. Moore**

25. FUNERAL DIRECTOR'S SIGNATURE

**Howard K. McCormick & Son**

ADDRESS

**Abingdon, Md.**DATE **Dec. 2, 1955**

DEPARTMENT OF HEALTH-EDUCATION- WELFARE

WISCONSIN STATE DEPARTMENT OF DEATH

RECEIVED  
DECEMBER 5 1955  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182

## 1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Bel-Air Rural

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

Lucella

(Middle)

(Last)

Cunningham

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Harford

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWNBel-Air Rural  
(If rural, give location)STREET  
ADDRESS4. DATE  
OF  
DEATH

November 12 1955

(Month) (Day) (Year)

yrs.

Months

Days

Hours

Min.

5. SEX:

Female

6. COLOR OR  
RACE

White

6. COLOR OR  
RACE

White

(Specify)

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED

Single

(Specify)

8. DATE OF BIRTH:

Dec. 23, 1875

(Specify)

9. AGE last birthday:

79

(Specify)

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY

10c. BIRTHPLACE (State or foreign country):

10d. CITIZEN OF WHAT  
COUNTRY?

House work at home

Harford Co., Md. U.S.A.

BUREAU V. S

NOV 25 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10880

## CERTIFICATE OF DEATH

10889

Reg. Dist. No. 183

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED					
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Hanford. MARYLAND Horne-de-Grace 40 min	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland COUNTY Hanford. Horne-de-Grace 24				
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) 553 Fountain ST						
3. NAME OF DECEASED (Type or Print)	(First) Jay	(Middle) Vernon	(Last) Disbrow.				
4. DATE OF DEATH	11	13	1955				
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	white	Married	Sept. 29 1906	41 8 49	Months	Deys	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retail Grocer		Grocery	Md.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
J. Sanford Disbrow		Sarah E. Griffith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		INTERVAL BETWEEN ONSET AND DEATH	
No		216-65-3723		Mrs. M. Lynple Disbrow			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 581.0 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u> ANTECEDENT CAUSE(S) DUE TO <u>Chronic Myocarditis - Atrophic Cardia.</u> DISEASES OR CONDITIONS, IF ANY, (B) <u>of Lungs</u> GIVING RISE TO THE ABOVE CAUSE STATEMENT UNDERLYING CAUSE LAST. DUE TO <u>of Lungs</u> (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-16</u> , <u>1955</u> , to <u>11-13</u> , <u>1955</u> , that I last saw the deceased alive on <u>11-13</u> , <u>1955</u> , and that death occurred at <u>4:45</u> P.M., from the causes and on the date stated above. SIGNATURE <u>A. L. Lewis, M.D.</u> ADDRESS (Street, city, town, state) <u>Hanford</u> DATE SIGNED <u>11-13-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
BURIAL		11-16-1955		ANGEL HILL		HANFORD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov-16-1955</u>		<u>A. L. Lewis</u>		<u>M. R. MADISON</u>		<u>M. MITCHELL</u>	

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W.S.B. 2.0 09.2002

~~W. L. Young, Jr. and D. L. Morris~~

BUREAU Y.

5561 87 100

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卷之三

3. *Therapeutic and social work*

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10902 CERTIFICATE OF DEATH

10890

181

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Hanford	MARYLAND	STATE Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN	Aberdeen		OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	US Army Hospital Aberdeen Proving Ground, Md.	STREET ADDRESS	Aberdeen
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH November 4 1955	
(First) Harold		(Middle) Dietz	
(Last) Duppstadt			
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Married	22 August 1909
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Engr	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? USA
46 yrs.	Army Ordnance	Ohio	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Edward L Duppstadt	Carrie Elea nor Dietz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
No	27309047		
17. INFORMANT & ADDRESS	Civilian Personnel		
Aberdeen Proving Ground, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
587.0 IMMEDIATE CAUSE (A) Gastrointestinal hemorrhage			
ANTECEDENT CAUSE(S) DUE TO 2 days			
DISEASES OR CONDITIONS, IF ANY, (B) Acute renal failure			
GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO 11 days			
(C) Acute hemorrhagic pancreatitis			
16 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING			
TO THE DEATH BUT NOT RELATED TO THE			
DISEASE OR CONDITION CAUSING DEATH. Cholecystitis with cholelithiasis			
years			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
None			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)
NA			(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?
	M. at work	White Not white at work	
22. I hereby certify that I attended the deceased from 18 Oct 1955, to 4 Nov 1955, that I last saw the deceased			
alive on 4 Nov 1955, and that death occurred at 1:15 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city, town, state) DATE SIGNED			
M.D. US Army Hospital, APG, Md. 4 Nov 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
Removal	Nov. 6-1955	Ligonier Valley Cemetery	Ligonier, Pennsylvania
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
DATE Nov. 5-55	Nellie Q. Perry	John G. Barringer - Aberdeen Rd.	



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10891

## 10903 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>MORRISVILLE</b>		STATE <b>Md.</b> COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>MORRISVILLE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.F.D. ROUTE 1</b> <b>STEWARTSTOWN, PENNA</b>		LENGTH OF STAY (in this place) <b>4 yrs</b>	
STREET ADDRESS <b>R.F.D. ROUTE 1</b>		<small>If rural give location)</small> <b>STEWARTSTOWN</b> <b>PENNA</b>	
3. NAME OF DECEASED (Type or Print) <b>MARY LOU BARBER</b>		4. DATE OF DEATH <b>11-19-55</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>12-27-1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		9. AGE last birthday <b>85</b> yrs. Months Days Hours Min.	
13. FATHER'S NAME <b>Geo. Heck</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS <b>L. MORGAN FITZELL BALTO 14</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIA LOHMLER</b>	
18. MEDICAL CERTIFICATION  <b>420.1</b> IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)  <b>Coronary Occlusion</b> <b>Arteriosclerotic Arteria Sclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>20 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June</b> , 19.55, to <b>Nov. 19, 19.55</b> , that I last saw the deceased alive on <b>Mar. 19, 19.55</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>William O'Fulton</b> M.D. ADDRESS (Street, city, town, state) <b>Stewartstown</b> DATE SIGNED <b>11/19/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>11-22-55</b>	
24. REC'D BY REGISTRAR DATE <b>NOV 21 1955</b>		REGISTRAR'S SIGNATURE <b>Trusilla Fornas</b>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John Bradley, Jr.</b>			



## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2, FilmGl89 11-28-55 et

## 10881 CERTIFICATE OF DEATH

10892

Reg. Dist. No. 185

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	MARYLAND		STATE	COUNTY	
Harford			Md.	Harford	
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Havre De Grace	6 WEEKS		TOWN Pikesville	8, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Harford Memorial Hospital		STREET ADDRESS	Harford Convalescent Home	
71			Mrs. James Watkins, 202 Clarendon Ave.		
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE (Month) OF DEATH Nov. 14 1955	
NEVA	LAWDER		GILBERT	(Dey)	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR
Fem.	Wh.	Single	Feb. 13, 1885	70 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Bldg. R.R. Clerk		BALTO. MD	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Jarrett N. GILBERT			Lydia LAWDER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(Yes, no, or unk.)		(If Yes, give war or dates of service)		Mr. Rue M. Gilbert Havre de Grace Md. RDF	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
443X IMMEDIATE CAUSE (A) Chr. Myocardial Disease					
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Chr. Hypertensive Cardio-vascular Disease					
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Dey) (Year) (Hour)		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 19, 1953, to Nov. 14, 1955, that I last saw the deceased alive on Nov. 13, 1955, and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city, town, state) DATE SIGNED Signature: Willard P. Hudson M.D. Forest Hill, Md. 11-15-55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL WESLEYAN CHAPEL		LOCATION (City, town, or county) HARFORD (State) MD.
BURIAL		11-18-1955			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE Nov. 17, 1955		L. L. Lewis M.D.		R. Madair Mitchell Havre de Grace M.D.	

ST. DOMINIC'S COLLEGE—MADRAS STATE—CHENNAI.

STATE OF TAMIL NADU

6 NOV 2

STATE OF TAMIL NADU  
6 NOV 2

A.2 5

13 NOV 1960 (TUESDAY)

15 NOV 1960

1960 NOV 5

1960 NOV 5

THE STATE OF TAMIL NADU

BUREAU V. 6

NOV 6 1960

11-18-1962 NICEVAN C. MALAR MURUGAN  
11-18-1962 NICEVAN C. MALAR MURUGAN  
11-18-1962 NICEVAN C. MALAR MURUGAN

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10893

## 10904 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)	
TOWN <u>Bel Air (Rural)</u>		20 years		TOWN <u>Bel Air Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS <u>Rock Spring Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>NANCY Charlotte GREER</u>			4. DATE (Month) (Day) (Year) OF DEATH <u>Nov. 1 1955</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 9 1877</u>	9. AGE last birthday yrs. <u>78</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>EIK Creek Md.</u>		
13. FATHER'S NAME <u>James Rudy</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <u>Y</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>✓</u>		
17. INFORMANT & ADDRESS <u>Garland Greer Bel Air, Md</u>			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>170X</u> IMMEDIATE CAUSE (A) <u>Carcinoma of breast</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____					
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>					
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <u></u> (State) <u></u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased <u>March 1955</u> , 19....., to <u>Nov. 1st, 1955</u> , that I last saw the deceased alive on <u>Oct. 30, 1955</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. SIGNATURE: <u>Willard P. Hedden M.D.</u> ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>11-2-55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov 4/1955</u>		NAME OF CEMETERY OR CREMATORIAL <u>Highland Presbyterian</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowood</u>		LOCATION (City, town, or county) <u>Hightland Hartford</u> (State) <u>MD</u>	
DATE <u>11-3-1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Daph Foster Bellair</u>		ADDRESS <u>Forest Hill, Md.</u>	

RECEIVED  
FEB 7 1955  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASH. 25, D. C.

REPORT OF THE  
DEPARTMENT OF JUSTICE

RECEIVED  
FEB 7 1955  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASH. 25, D. C.

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U. S. DEPARTMENT OF JUSTICE  
WASH. 25, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Hartford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Hartford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Rock's</i>		CITY (If outside corporate limits write RURAL and give nearest town) <i>Rock's</i>	
LENGTH OF STAY (in this place) <i>Life</i>		STREET ADDRESS (If rural, give location) <i>1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (First) <i>Earl</i>	(Middle) <i>S</i>	(Last) <i>Harris</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>November 4 1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>too</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>SING</i>	8. DATE OF BIRTH: <i>July 5-1955</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <i>✓</i>	
11. BIRTHPLACE (State or foreign country): <i>Rock's Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME: <i>George Harris</i>		14. MOTHER'S MAIDEN NAME: <i>Ada Higgins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>✓</i>	16. SOCIAL SECURITY NO.: <i>✓</i>		17. INFORMANT & ADDRESS: <i>Street #1 Ada Higgins Rock's Boyz</i>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <i>7720 Malnutrition</i>			
Immediate cause (a) <i>Malnutrition</i> DUE TO			
Antecedent cause(s) Diseases or conditions, if any, (b) ..... giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>A vitaminoisis</i>			
19a. DATE OF OPERATION: <i>✓</i>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) <i>✓</i>	(County) <i>✓</i> (State) <i>✓</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? at work <input type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Lerold C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	DATE SIGNED <i>11/4/55</i>
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>10/15/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Rock's Church</i>	LOCATION (City, town, or county) <i>Rock's Hartford Md</i> (State) <i>✓</i>
DATE REC'D BY LOCAL REG. <i>11-4-55</i>	REGISTRAR'S SIGNATURE <i>Priscilla Forward</i>	24. FUNERAL DIRECTOR <i>Jos T. T. Bellan Md</i>	ADDRESS <i>✓</i>

BUREAU V. S.

NOV 7 1955

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18****10882 CERTIFICATE OF DEATH**

10895

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
CITY <small>(If outside corporate limits, write RURAL OR and give nearest town)</small> TOWN <small>24</small> <i>Hanover Chase</i>		STATE <small>CITY (If outside corporate limits, write RURAL and give nearest town)</small> TOWN <small>24</small> <i>Hanover Chase</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>000</i>		LENGTH OF STAY <small>(in this place)</small> <i>37 yrs.</i>	
STREET ADDRESS <i>716 Green</i>		STREET ADDRESS <i>716 Green</i>	
<b>3. NAME OF DECEASED</b> <small>(Type or Print)</small> <i>John James Heath</i>		<b>4. DATE OF DEATH</b> <i>11/6/55</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>5/24/1897</i>
9. AGE last birthday <small>yr.</small> <i>58</i>	10. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> <i>Mechanic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>A. T. T.</i>	11. BIRTHPLACE <small>(State or foreign country)</small> <i>Dalystown, Pa.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	13. FATHER'S NAME <i>John Heath</i>		
14. MOTHER'S MAIDEN NAME <i>Caroline Bocourt</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(Yes, no, or unk.)</small> <i>No</i>	
16. SOCIAL SECURITY NO. <i>087-10-3637</i>		17. INFORMANT & ADDRESS <i>Mrs. June H. Heath Hanover Chase</i>	
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1</i>			
IMMEDIATE CAUSE <i>(A)</i> <i>Coronary Thrombosis</i>			
ANTECEDENT CAUSE(S) DUE TO <i>(B)</i> <i>Arterio Thrombosis Cardio</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>(C)</i> <i>Vascular Disease Hypertension</i>			
STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, NOTIFY MEDICAL EXAMINER)</small>	21b. PLACE <small>(Home, farm, factory, OF INJURY street, office bldg., etc.)</small>		21c. WHERE DID INJURY OCCUR? <small>(City or town)</small> <i>(County)</i> <small>(State)</small>
21d. TIME OF INJURY <small>(Month) (Day) (Year) (Hour)</small>	21e. INJURY OCCURRED <small>M. at work</small> <input type="checkbox"/> <small>Not while at work</small> <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/6/55</i> , 1955, to <i>11/6/55</i> , 1955, that I last saw the deceased alive on <i>11/6/55</i> , 1955, and that death occurred at <i>9:15A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Charles J. Foley</i> M.D. <i>4000 N. Penns. Av. Hanover Chase, Md.</i> DATE SIGNED <i>11/6/55</i>			
23. BURIAL, CREMATION, REMOVAL. (SPECIFY) <i>Burial</i>	DATE THEREOF <i>11/9/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion</i>	LOCATION <small>(City, town, or county)</small> <i>(State)</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>C. L. Lewis M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Planning for Hanover Chase M.D.</i>	ADDRESS
DATE <i>Nov 9 1955</i>		ADDRESS <i>716 Green Hanover Chase, Md.</i>	

81. DEPARTMENT OF TRANSPORTATION STATE OF CALIFORNIA

STATE OF CALIFORNIA

NOV 10 1968

DEPARTMENT OF TRANSPORTATION STATE OF CALIFORNIA

11000

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NOTARIZED DOCUMENT

NOTARIZED

NOV 10 1968

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

10883

**CERTIFICATE OF DEATH**

10896

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>24 HAVRE de Grace</b>		STATE <b>MARYLAND</b> LENGTH OF STAY (in this place) <b>2 days</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>71 HARFORD MEMORIAL Hosp</b>		STATE <b>Maryland</b> COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Aberdeen</b> STREET ADDRESS <b>Edmond St</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>JOHN E HUBARD</b>		<b>4. DATE</b> (Month) <b>11</b> (Day) <b>29</b> (Year) <b>1955</b> <b>OF DEATH</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Sept 8 - 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Dep't</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-05-4375</b>	
17. INFORMANT & ADDRESS <b>Mrs Sabie Hubard Aberdeen Md.</b>		18. MEDICAL CERTIFICATION	
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>443X</b> IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Hypertensive Cardiovascular disease</b>			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <b>1411</b> (County) <b>Baltimore</b> (State) <b>Md.</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		M. <input type="checkbox"/> at work <input type="checkbox"/>	
<b>22. I hereby certify</b> that I attended the deceased from <b>1411</b> , 19 <b>53</b> , to <b>11/29/55</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>11/29/55</b> , 19 <b>55</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. <b>SIGNATURE</b> <i>George J. Stansbury, M.D.</i> DATE SIGNED <b>11/29/55</b> <b>ADDRESS</b> (Street, city, town, state) <b>529 Revolution St, Havre de Grace, Md.</b> <b>(State)</b> <b>Md.</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12/3/55</b> NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary Cemetery</b> LOCATION (City, town, or county) <b>Aberdeen</b> (State) <b>Md.</b>	
24. REC'D BY REGISTRAR <b>REC'D. 1-1965</b>		REGISTRAR'S SIGNATURE <b>G. L. Lewis M.D.</b> FUNERAL DIRECTOR'S SIGNATURE <b>John G. Farriug Aberdeen</b> ADDRESS <b>1411</b> (State) <b>Md.</b>	
DATE <b>REC'D. 1-1965</b>		FUNERAL DIRECTOR'S SIGNATURE <b>John G. Farriug Aberdeen</b> ADDRESS <b>1411</b> (State) <b>Md.</b>	

ST. MARYS-PALESTINE STATE CHARTER

STATE OF TEXAS  
CERTIFICATE OF BIRTH

RECORDED IN THE OFFICE OF THE

REGISTRATION AND RECORDS DEPARTMENT

OF THE STATE OF TEXAS

AT THE CITY OF AUSTIN

ON THE TWENTY-THREE DAY OF NOVEMBER

ONE THOUSAND NINETEEN FIFTY-FIVE

BY THE STATE CLERK

FOR THE STATE OF TEXAS

AT THE CITY OF AUSTIN

ON THE TWENTY-THREE DAY OF NOVEMBER

ONE THOUSAND NINETEEN FIFTY-FIVE

BY THE STATE CLERK

FOR THE STATE OF TEXAS

AT THE CITY OF AUSTIN

ON THE TWENTY-THREE DAY OF NOVEMBER

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BY THE STATE CLERK

FOR THE STATE OF TEXAS

AT THE CITY OF AUSTIN

ON THE TWENTY-THREE DAY OF NOVEMBER

ONE THOUSAND NINETEEN FIFTY-FIVE

BY THE STATE CLERK

FOR THE STATE OF TEXAS

AT THE CITY OF AUSTIN

ON THE TWENTY-THREE DAY OF NOVEMBER

ONE THOUSAND NINETEEN FIFTY-FIVE

BY THE STATE CLERK

FOR THE STATE OF TEXAS

JOHN CHRISTIAN JACOBSEN

BUREAU V.

DEC 2 1955

REGISTRY

10884

10897

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 1801

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <i>Harford</i> STATE <i>Maryland</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Landi-Grace</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Landi-Grace</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) <i>3 yrs</i>	
3. NAME OF DECEASED: (Type or Print)		(First) <i>Mary</i> (Middle) <i>Jones</i> (Last)	4. DATE OF DEATH <i>November 24 1953</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>5/30/1878</i> 9. AGE last birthday: <i>77</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Landlady</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	11. BIRTHPLACE (State or foreign country): <i>Federick</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>Charles Palmer</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Doyle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <i>James P. Palmer 1404 Harford Ave. Baltimore, Md.</i>	
17. INFORMANT & ADDRESS: <i>James P. Palmer 1404 Harford Ave. Baltimore, Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <i>422.1</i> Immediate cause (a) <i>Arteriosclerotic Cerebrise</i> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, (b) giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	DATE SIGNED <i>11/24/55</i>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>		DATE THEREOF <i>11/27/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Landi-Grace</i> LOCATION (City, town, or county) <i>Landi-Grace, Md.</i> (State)
DATE REC'D BY LOCAL REG. <i>Nov 27 1955</i>		REGISTKAR'S SIGNATURE <i>G. L. Lewis, M.D.</i>	24. FUNERAL DIRECTOR ADDRESS <i>Landi-Grace, Landi-Grace, Md.</i>

RECEIVED  
BUREAU V. S.  
NOV 29 1955

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10885

## CERTIFICATE OF DEATH

10898

Reg. Dist. No.

181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY OR TOWN		Harford. Maryland		STATE CITY OR TOWN		Maryland COUNTY Harford	
31 31		33 Tuerson Street. Maryland		31 31		33 Tuerson Street. Maryland	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Male		white		Single		Nov 27th 1955	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
laufant				laufant			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William L. Jewell, Jr.				Barbara Cook.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No				laufant		222 Post Rd. Zero Arthur Cook, Aberdeen, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 493X IMMEDIATE CAUSE (A) acute infection - Pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
INTERVAL BETWEEN ONSET AND DEATH 1-2 hours							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... 1955, to ..... 1955, that I last saw the deceased alive on ..... 1955, and that death occurred at ..... A.M., from the causes and on the date stated above. SIGNATURE <i>J. J. Johnson</i> ADDRESS (Street, city, town, state) <i>1770 Charles Blvd Aberdeen, Md.</i> DATE SIGNED <i>11/28/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Nov 30-1955</i>		NAME OF CEMETERY OR CREMATORIAL <i>Bethel Memorial Gardens</i>		LOCATION (City, town, or county) <i>Bethel Maryland</i>	
24. REC'D BY REGISTRAR <i>Mellie R. Penny</i>		REGISTRAR'S SIGNATURE <i>Mellie R. Penny</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarrington Aberdeen, Md.</i>		ADDRESS	
DATE <i>Nov. 30-55</i>							

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CERTIFICATE OF DEATH

BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 15-5 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10886

## CERTIFICATE OF DEATH

10899

Reg. Dist. No. 180-

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	<i>Harford</i>	MARYLAND LENGTH OF STAY (in this place)	MARYLAND COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<i>Harve de grace</i>	<i>Dora</i>	<i>Harve de grace</i>	
71 <i>Harford Memorial Hospital</i>		24 <i>101 N. Union Ave</i>		
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>		
<i>Red Floyd</i>		November 20 1955		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>MAR. 15, 1902</i>	
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
<i>53</i>	<i>Clergyman</i>	<i>Meth. CHORET</i>	<i>BALTO. MD.</i>	
12. CITIZEN OF WHAT COUNTRY?	<i>U.S.A.</i>			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
<i>Wm. F. KRUG SR.</i>	<i>ELIZABETH BALSTER</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.			
<i>Yes</i>	<i>17. INFORMANT &amp; ADDRESS</i>			
(If Yes, give war or dates of service)		<i>Mrs. MARIE R. KRUG</i>		
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>Cardiac disease</i>		
422.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO		<i>Cardiac disease</i>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		<i>Cardiac disease</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>2-12</i> , 19 <i>55</i> , to <i>11-20</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11-20</i> , 19 <i>55</i> , and that death occurred at <i>2-12</i> M. from the causes and on the date stated above. SIGNATURE <i>A. L. Lewis M.D.</i> ADDRESS (Street, city, town, state) <i>Harve de grace, Md</i> DATE SIGNED <i>11-22-55</i>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREON	NAME OF CEMETERY OR CREMATORI	LOCATION (City, town, or county)	(State)
<i>BURIAL</i>	<i>11-23-55</i>	<i>WOODSTOCK PARKWOOD</i>	<i>BALTO. C. C.</i>	<i>MD.</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE
DATE <i>Nov. 22-1955</i>	<i>A. L. Lewis M.D.</i>			<i>P. MADISON Mitchell</i>
ADDRESS <i>HARVE DE GRACE MD.</i>				

60201

MISSOURI STATE DEPARTMENT OF HEALTH-PUBLIC HEALTH

STATE CERTIFICATE OF DEATH

SEARCHED

WV 15.12.100-23

124

MR. CHARLES L. BURTON MD.

SEARCHED  
INDEXED  
FILED

ELIASADETH BURTON  
WV 15.12.100-1150

MR. E. H. L. 26

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BUREAU V. S.

NOV 22 1955

RECEIVED  
WV STATE DEPT. OF HEALTH

11-23-22 MEDICAL RECORDS BURTON C. S.  
LUDWIGSHEIM

RECORDED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10.M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10900

## 10887 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Md COUNTY Cecil Port Deposit (If rural give location)		
24 Havre De Grace		11 Harford Memorial Hospital		78 N. Main St		07X-2		
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)				
Harry		James		Mason		Nov. 3 1955		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 23, 1890	9. AGE last birthday 65	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Day			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME John Perry Mason				14. MOTHER'S MAIDEN NAME Sallie E. Dunmore				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 213-08-0828		17. INFORMANT & ADDRESS Alice M. Hughes, Port Deposit, Md.				
18. MEDICAL CERTIFICATION								
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>Diabetes Mellitus with Azotemia</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Arterosclerotic Heart disease</u>								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bronchitis with pleuritis								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 4/1/1951 to 11/3/1955, that I last saw the deceased alive on 11/3/1955, and that death occurred at 12:35 A.M. from the causes and on the date stated above. SIGNATURE <u>George J. Stansbury</u> M.D. 569 Revolution St., Havre de Grace, Md. 11/3/55 DATE SIGNED								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-6-1955		NAME OF CEMETERY OR CREMATORIUM Cokesbury Cemetery		LOCATION (City, town, or county) Port Deposit, Md. Rural		
24. REC'D BY REGISTRAR DATE Nov. 5-1955		REGISTRAR'S SIGNATURE A. L. Lewis m. d.		25. FUNERAL DIRECTOR'S SIGNATURE Vera Patterson & Son		ADDRESS Perryville, Md.		



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10888

## CERTIFICATE OF DEATH

12012

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Maryland COUNTY Upper Harford Monkton (If rural give location)	
24 Harve de Grace		1 month		STREET ADDRESS			
71 Harford Memorial Hospital		R.D. #1 - Box 131					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH November 21 1955			
(Type or Print)		Baby Ann McCann		(Month) (Day) (Year)			
5. SEX F	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Newborn	8. DATE OF BIRTH 11/20/55	9. AGE last birthday 12 months	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Ray McCann				14. MOTHER'S MAIDEN NAME Eloise Easter Hosp Records.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
(If Yes, give war or dates of service)							
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.5 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) _____ (B) _____ (C) _____				Respiratory failure Fetal asphyxia Extreme prematurity			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... , that I last saw the deceased alive on ..... 19 ..... , and that death occurred at ..... 3:12 am ..... M. from the causes and on the date stated above. SIGNATURE <i>John Morrissey</i> ADDRESS (Street, city, town, state) <i>Harve de Grace</i> DATE SIGNED <i>11-21-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 11-21-55		NAME OF CEMETERY OR CREMATORIUM Harford Memorial Hospital		LOCATION (City, town, or county) (State) Harve de Grace, Md	
24. REC'D BY REGISTRAR DATE <i>Dec. 6-1955</i>		REGISTRAR'S SIGNATURE G. L. Lewis M. D.		25. FUNERAL DIRECTOR'S SIGNATURE H. George Kelly, Administrator		ADDRESS	

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BY PROCLAMATION OF THE UNITED STATES OF AMERICA.

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BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10906 CERTIFICATE OF DEATH

10901  
182

Reg. Dist. No. ....

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY <del>CITY</del> (If outside corporate limits, write RURAL OR end give nearest town) TOWN <i>Harford Street</i>		MARYLAND LENGTH OF STAY (in this place) <i>life</i>		STATE <del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Harford Street</i>		COUNTY <del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <i>Harford</i>		
3. NAME OF DECEASED (Type or Print) <i>Mary G. Neal</i>				4. DATE (Month) (Day) (Year) OF DEATH <i>Nov. 15 1955</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>July 15 1875</i>	9. AGE last birthday 90	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife at home</i>		11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>Harford Co., Md.</i>
13. FATHER'S NAME <i>John J. Healy</i>		14. MOTHER'S MAIDEN NAME <i>Martha Biggles</i>		15. CITIZEN OF WHAT COUNTRY? <i>None</i>				
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		17. SOCIAL SECURITY NO. <i>None</i>		18. INFORMANT & ADDRESS <i>Marshall &amp; Carverhouse</i>				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>32IX</i>				19. MEDICAL CERTIFICATION <i>cerebral hemorrhage Atherosclerosis of the arteries</i>				
IMMEDIATE CAUSE <i>(A)</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>(B)</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1-2 months</i>				
DUE TO <i>(C)</i>								
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION		21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>None</i>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>None</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>None</i>		
21f. HOW DID INJURY OCCUR? <i>None</i>								
22. I hereby certify that I attended the deceased from <i>September 1955</i> to <i>November 1955</i> , that I last saw the deceased alive on <i>September 1955</i> , and that death occurred at <i>None</i> M, from the causes and on the date stated above. SIGNATURE <i>John O'Donnell M.D.</i>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>Nov. 18, 1955</i>		NAME OF CEMETERY OR CREMATORIAL <i>Ascension Cem. Harford Co., Md.</i>		
24. REC'D BY REGISTRAR <i>None</i>				REGISTRAR'S SIGNATURE <i>C. P. Kirk</i>		LOCATION (City, town, or county) (State) <i>None</i>		
DATE <i>Nov. 16, 1955</i>				25. FUNERAL DIRECTOR'S SIGNATURE <i>John Bailey</i>		ADDRESS <i>None</i>		

DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION  
WISCONSIN STATE GRANT - CHICAGO - BUREAU

WISCONSIN STATE GRANT - CHICAGO - BUREAU

WISCONSIN STATE GRANT - CHICAGO - BUREAU

BUREAU V. S.

NOV 22 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10907 CERTIFICATE OF DEATH

10902

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Hartford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Hartford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Street</i>		LENGTH OF STAY (in this place) <i>2 Months</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>100</i>		STREET ADDRESS <i>Street</i>	
(Type or Print)		(If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
<i>Cristine Marie Presbury</i>		Nov 22 1955	
S. SEX <i>F</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>Sept 14 1955</i>
9. AGE last birthday <i>2 Months</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Havrede Grace Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Charles Presbury</i>	14. MOTHER'S MAIDEN NAME <i>Dorothy Rice</i>	17. INFORMANT & ADDRESS <i>Charles Presbury 57 Street, Md</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>2</i>	16. SOCIAL SECURITY NO. <i>✓</i>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  491 X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) <i>Peripheral Vascular Disease</i> (B) <i>Ac Capillary Bronchitis</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>✓</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <i>✓</i>	21c. WHERE DID INJURY OCCUR? (City or town) <i>✓</i>	(County) <i>✓</i> (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>	21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sept 14 1955</i> to <i>Nov 22 1955</i> , that I last saw the deceased alive on <i>Nov 17 1955</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Willard P. Hudson</i>		ADDRESS (Street, city, town, state) <i>Forest Hill</i>	DATE SIGNED <i>11/23/55</i>
23. FURNAL, Cremation, REMOVAL (Specify) <i>BURIAL</i>	DATE THEREOF <i>Nov 23 1955</i>	NAME OF CEMETERY OR CREMATORIY <i>Fairview</i>	LOCATION (City, town, or county) <i>Forest Hill Hartford Md</i>
24. REC'D BY REGISTRAR <i>✓</i>	REGISTRAR'S SIGNATURE <i>Barbara Lowood</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph T. Tote</i>	
DATE <i>11-23-55</i>		ADDRESS <i>Bellair Md</i>	

THE STATE OF TEXAS - DEPARTMENT OF PUBLIC SAFETY

DEATH CERTIFICATE

BUREAU V. S.

NOV 22 1955

RECEIVED

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10908 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 187  
Reg. Dist. 10903

1. PLACE OF DEATH: COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Whiteford Rural</i>		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rebbit and Whiteford Road.</i>		STREET ADDRESS <i>113 Law Street.</i>	
3. NAME OF DECEASED: (Type or Print) <i>Dorscy E Purwell</i>		(First) <i>Dorscy</i> (Middle) <i>E</i> (Last) <i>Purwell</i>	4. DATE OF DEATH <i>November 29 1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>January 26 1903</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Refugee Augueen</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
13. FATHER'S NAME: <i>George Edward Purwell</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Martha Poe</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Glenra Traity 118 Law St Aberdeen</i>		18. MEDICAL CERTIFICATION <i>coronary occlusion</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <i>420.1</i> Immediate cause (a) DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause DUE TO stating underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	
SIGNATURE <i>Leroy E Palmer</i>		DATE SIGNED <i>11/29/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Removal</i>		DATE THEREOF <i>12/1/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Oakland Cemetery</i>
DATE REC'D BY LOCAL REG. <i>Nov. 30 - 55</i>		REGISTRAR'S SIGNATURE <i>Miss Purcell Brooks</i>	LOCATION (City, town, or county) <i>Oakland Maryland</i>
		24. FUNERAL DIRECTOR <i>John G Farling Aberdeen</i>	ADDRESS <i>—</i>

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10889 CERTIFICATE OF DEATH

10904

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Hause de Grace</u>		STATE <u>Md</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 Harford Memorial Hospital</u>		LENGTH OF STAY (in this place) <u>16 days</u>	
3. NAME OF DECEASED (Type or Print) <u>Richard Rasnake</u>		STREET ADDRESS <u>Route # 2</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1008 Feb 1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax Collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various works</u>	
13. FATHER'S NAME <u>HERMAN Rasnake</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Hereman Rasnake Aberdeen #2</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>612X IMMEDIATE CAUSE (A) PULMONARY EMBOLISM</u> <u>ANTECEDENT CAUSE(S) DUE TO</u> <u>DISEASES OR CONDITIONS, IF ANY, (B) POST-OPERATIVE</u> <u>GIVING RISE TO THE ABOVE CAUSE STATEMENT DUE TO</u> <u>STATING UNDERLYING CAUSE LAST. (C) PROSTATECTOMY</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>11-22-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>VERY LARGE PROSTATE</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21e. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>Nov. 12, 1955</u> , to <u>Nov. 29, 1955</u> , that I last saw the deceased alive on <u>11-28, 1955</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above. <b>SIGNATURE</b> <u>James M. E. Finney</u> <b>ADDRESS</b> (Street, city, town, state) <u>RED, Aberdeen Md.</u> <b>DATE SIGNED</b> <u>11-30-55</u> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/2/55</u> NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Park Bel Air Maryland.</u> LOCATION (City, town, or county) <u>—</u> (State) <u>—</u>	
24. REC'D BY REGISTRAR <u>See 1-1955 - G. L. Lewis M. A.</u>		REGISTRAR'S SIGNATURE <u>John G. Farney Aberdeen Md.</u> ADDRESS <u>—</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Farney Aberdeen Md.</u>			
DATE <u>Dec 1-1955</u>			

BUREAU V. S.

DEC 2 1955

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DEC 2 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL**: The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V\$ A15C 1-55 10M

10909 CERTIFICATE OF DEATH

Reg. Dist. No. 802

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Hartford</b> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <b>Cooktown</b>		STATE <b>MD</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Ridgeway</b> STREET ADDRESS <b>Rocky Rd</b> (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		LENGTH OF STAY (In this place) <b>62 yrs</b>	
3. NAME OF DECEASED (Type or Print) <b>HENRY</b>		4. DATE (Month) OF DEATH Nov. 1st 1955	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <b>MARRIED</b>	8. DATE OF BIRTH <b>Oct. 18, 1893</b> 62
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman, Seaman, General</b>		9. AGE last birthday IF UNDER 1 YEAR yrs. <b>62</b> Months Days Hours Min.	
13. FATHER'S NAME <b>George B. Ridgdon</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>— ?</b>	
17. INFORMANT & ADDRESS <b>Mrs Margaret L. Ridgdon</b>		18. MEDICAL CERTIFICATION <b>None</b>	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis</b>		20. INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <b>(B) Chr. coronary artery disease</b>		? <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>None</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 1, 1955, to Nov. 1, 1955, that I last saw the deceased alive on Nov. 1, 1955, and that death occurred at 4:12 P.M. from the causes and on the date stated above. SIGNATURE <b>Willard P. Hudson</b> M.D. ADDRESS (Street, city, town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>11-2-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Nov. 3, 1955</b>	
24. REC'D BY REGISTRAR <b>Priscilla Sowood</b>		NAME OF CEMETERY OR CREMATORIUM <b>Wm. Walter, Mem. Forest Hill</b>	
REGISTRAR'S SIGNATURE <b>Priscilla Sowood</b>		LOCATION (City, town, or county) <b>Cooktown, Hartford, Md.</b> (State)	
DATE 11-4-55		25. FUNERAL DIRECTOR'S SIGNATURE <b>Martin G. Knutson</b> ADDRESS	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10890 CERTIFICATE OF DEATH

10906

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY 24 HARFORD		MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN Rural—Forest Hill HARFORD MEMORIAL Hospital		STATE Md.		COUNTY HARFORD CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural—Forest Hill, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 HARFORD MEMORIAL Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) MAUD				4. DATE (Month) (Day) (Year) OF DEATH November 5, 1955			
5. SEX - Fem	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH July 27, 1890	9. AGE last birthday 65 yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Harford Co. Md.	12. CITIZEN OF WHAT COUNTRY USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				13. FATHER'S NAME Frank Grafton			
14. MOTHER'S MAIDEN NAME Lavinia Thomas				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.			
16. SOCIAL SECURITY NO. None				17. INFORMANT & ADDRESS Mrs Paul Peak, Forest Hill, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Peripheral Vascular Collapse and Terminal Pneumonia				18. MEDICAL CERTIFICATION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Chr. Cardio-vascular Disease DUE TO (C) Chr. Essential Hypertension			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 16 yrs.			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 10, 1938, to Nov. 5, 1955, that I last saw the deceased alive on 11-5-55, 19, and that death occurred at 1:00 P.M. from the causes and on the date stated above. SIGNATURE Willard P. Hickey, M.D. Forest Hill, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov 7/55		NAME OF CEMETERY OR CREMATORIAL Center Methodist		LOCATION (City, town, or county) Forest Hill Harford Md	
24. REC'D BY REGISTRAR DATE Nov 9-1955		REGISTRAR'S SIGNATURE G. L. Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Joseph Foster Bellin, M.D.		ADDRESS	

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STATE OF STADTREICH

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10910 CERTIFICATE OF DEATH

10907

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Belair		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		COUNTY (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Harford Convalescing Home				STREET ADDRESS 6315 Hudson Street 3 Vol-4			
3. NAME OF DECEASED (First) MARY (Middle) E. (Last) SCOTT				4. DATE OF DEATH NOV. 7, 1955			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Dec. 25, 1876	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown				14. MOTHER'S M AIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Virginia Hershey, 3593 Shannon Dr.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443 X IMMEDIATE CAUSE (A) Lobar (hypostatic) Pneumonia(terminal) INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Chr. hypertensive cardio-vascular disease ? GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Forest Hill, Md.		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 3, 1954, to Nov. 7, 1955, that I last saw the deceased alive on Nov. 7, 1955, and that death occurred at 11:15P.M., from the causes and on the date stated above. SIGNATURE Willard P. Hudson, M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 11/10/55		NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		ADDRESS (Street, city, town, state) Forest Hill, Md.	
24. REC'D. BY REGISTRAR DATE Nov. 14, 1955		REGISTRAR'S SIGNATURE Pamela Townsend		25. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Jr.		ADDRESS 1217 St. Paul Street	

83 DEPARTMENT OF STATE - FEBRUARY 20, 1945

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10911 CERTIFICATE OF DEATH

10908  
Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>				
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY H Arford		
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>NEAR Bel Air</b>		LENGTH OF STAY (in this place) <b>4 weeks</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Havre de Grace</b>		STREET ADDRESS <b>607 Pearl Street</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Walters Nursing Home</b>								
<b>3. NAME OF DECEASED</b> (First) <b>NICOLA</b> (Middle) <b>SERPENTINO</b> (Type or Print)				<b>4. DATE</b> (Month) <b>Nov.</b> (Day) <b>25,</b> (Year) <b>1955</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>12/27/ 1878</b>	9. AGE last birthday <b>76</b>	IF UNDER 1 YEAR Months <b>0</b> Deys <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Calliva Serpentino</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>217-03-0884</b>		17. INFORMANT & ADDRESS <b>Archille Sarvino, 607 Pearl St.</b>				
18. MEDICAL CERTIFICATION								
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>443X</b> IMMEDIATE CAUSE (A) <b>CERERAL HEMORRHAGE (2nd episode)</b> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO <b>Hypertensive cardio-vascular disease</b> ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, (B) ? GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <b>Forest Hill, Md.</b>		(County) <b>Forest Hill, Md.</b> (State) <b>Md.</b>		
21d. TIME OF INJURY (Month) <b>Nov.</b> (Day) <b>4</b> (Year) <b>1955</b>		21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Nov. 25, 1955</b>				
22. I hereby certify that I attended the deceased from <b>Nov. 4, 1955</b> , to <b>Nov. 25, 1955</b> , that I last saw the deceased alive on <b>Nov. 25, 1955</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>Willard P. Hudson</b> M.D. ADDRESS (Street, city, town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>11-26-55</b>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>11/28/1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>MT. ERIN</b>		LOCATION (City, town, or county) <b>HAURE de GRACE, Md.</b>		
24. REC'D BY REGISTRAR <b>Priscilla Forward</b>		REGISTRAR'S SIGNATURE <b>M</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>				
DATE <b>11-28-55</b>								

1. ANOMALY-HIGH TO THE TRANSITION STATE ONLY

STATEMENT OF DEBT

BUREAU V.

551 00 NOV

REGEV ED

## 10891 CERTIFICATE OF DEATH

Reg. Dist. No. 182

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-25 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY 32	HARFORD	MARYLAND	CITY (if outside corporate limits, write RURAL OR TOWN BEL AIR, Md.)			
LENGTH OF STAY (in this place) 2 yrs.		STATE MARYLAND COUNTY HARFORD				
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 116 WILLIAMS St.		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN BEL AIR.				
STREET ADDRESS 116 WILLIAMS St.		STREET ADDRESS (If rural give location)				
3. NAME OF DECEASED (First) ROBERT (Middle) KIMBLE (Last) SOUTER		4. DATE (Month) NOV. 18 (Day) (Year) 1955				
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH JULY 2, 1916			
9. AGE last birthday 39 yrs.	10. KIND OF BUSINESS OR INDUSTRY Aeronautics	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ROBERT WILLIAM SOUTER	14. MOTHER'S MAIDEN NAME BERTHA KIMBLE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes	16. SOCIAL SECURITY NO. 066-14-8919	17. INFORMANT & ADDRESS Marjorie Souter (wife)	18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 154X IMMEDIATE CAUSE (A) CARCINOMA of Rectum with widespread metastases ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	19. DATE OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH 4 Months
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Nov. 13, 1955, to Nov. 18, 1955, that I last saw the deceased alive on Nov. 17, 1955, and that death occurred at 11:30 A.M. from the causes and on the date stated above. SIGNATURE Paul S. Stoner Jr.						
23. DATE OF CREMATION, REMOVAL (SPECIFY) 11-22-55	DATE THEREOF 10	NAME OF CEMETERY OR CREMATORIAL Laurel Cemetery	ADDRESS (Street, city, town, state) M.D. 115 FULFORD Ave. BEL AIR MD Nov. 18, 1955	DATE SIGNED 1955		
24. RECED BY REGISTRAR Patterson	REGISTRAR'S SIGNATURE Priscilla Fownd	25. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Fasted	ADDRESS Bel Air Md			
DATE 11-19-55						

1900  
11  
MATERIALS STATE LABORATORY OF IOWA - BALTIMORE, MD

1920 CERTIFICATE OF DEATH

DECEASED PERSON'S NAME: JAMES J. MURPHY

REPORT NO. 12-A-24

DECEASED  
NAME

RECEIVED  
BUREAU V. S.

NOV 2 1920



## CERTIFICATE OF DEATH

BUREAU OF

GENERAL INSURANCE: HOME OF THE DECEASED

NAME OF DECEASED: JOHN R. SMITH

ADDRESS: 1234 BROAD ST., BALTIMORE, MD.

AGE: 65 YEARS

SEX: MALE

MATERIAL: BONE

TIME OF DEATH: 10:00 A.M.

TIME OF AUTOPSY: 11:00 A.M.

TIME OF EXAMINATION: 12:00 P.M.

TIME OF REPORT: 1:00 P.M.

TIME OF DEATH: 10:00 A.M.

TIME OF AUTOPSY: 11:00 A.M.

TIME OF EXAMINATION: 12:00 P.M.

TIME OF REPORT: 1:00 P.M.

TIME OF DEATH: 10:00 A.M.

TIME OF AUTOPSY: 11:00 A.M.

TIME OF EXAMINATION: 12:00 P.M.

TIME OF REPORT: 1:00 P.M.

TIME OF DEATH: 10:00 A.M.

TIME OF AUTOPSY: 11:00 A.M.

TIME OF EXAMINATION: 12:00 P.M.

TIME OF REPORT: 1:00 P.M.

TIME OF DEATH: 10:00 A.M.

TIME OF AUTOPSY: 11:00 A.M.

TIME OF EXAMINATION: 12:00 P.M.

TIME OF REPORT: 1:00 P.M.

NAME OF DOCTOR

ADDRESS

CITY

STATE

ZIP CODE

NAME OF DOCTOR

ADDRESS

CITY

STATE

ZIP CODE

RECEIVED  
BUREAU V. S.  
MAY 21 1955

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after this

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10892 CERTIFICATE OF DEATH

10911

Reg. Dist. No. 181

## 1. PLACE OF DEATH

COUNTY

Harford.

31

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)  
TOWN

Aberdeen

MARYLAND

LENGTH OF STAY  
(In this place)

—

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

214 Paradise Rd.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland.

COUNTY

Harford.

CITY  
OR  
TOWN

Aberdeen.

31

STREET  
ADDRESS

(If rural give location)

214 Paradise Road.

3. NAME OF  
DECEASED  
(Type or Print)

(First) Chester Le Roy Stephens

(Middle)

(Last)

4. DATE (Month)  
OF  
DEATH(Day)  
(Year)

Nov 16th 1955

## 5. SEX

Male

6. COLOR OR  
RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

Married

## 8. DATE OF BIRTH

Sept 16th 1888

## 9. AGE last birthday

67

yrs.

10. IF UNDER 1 YEAR  
Months Dey11. IF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Gas Utilities former retired U.S. Post. A.P.G.

10b. KIND OF BUSINESS  
OR INDUSTRY

Pennsylvania.

## 11. BIRTHPLACE (State or foreign country)

Pennsylvania.

12. CITIZEN OF WHAT  
COUNTRY?

USA.

## 13. FATHER'S NAME

Wm Ross Stephens

## 14. MOTHER'S MOTHER NAME

Eva Jane Rigore

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

215-24-7271

## 17. INFORMANT &amp; ADDRESS

Mrs Chester L. Stephens Aberdeen

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

40.1

(A)

Acute Coronary Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

None

## IMMEDIATE CAUSE

(A)

DUE TO

## ANTECEDENT CAUSE(S)

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. While at work  Not while  at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1955, to Nov 16 1955, that I last saw the deceasedalive on Nov 15 1955, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

SIGNATURE

Hedley Philbin M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

11/17/55

23. BURIAL, CREMATION  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

11/19/55

## NAME OF CEMETERY OR CREMATORIUM

Selby meth. Cemetery

## LOCATION (City, town, or county)

Yelta, R.R. York Co. Penna.

(State)

## 24. REC'D BY REGISTRAR

Dellie Q. Perry

## REGISTRAR'S SIGNATURE

Dellie Q. Perry

## 25. FUNERAL DIRECTOR'S SIGNATURE

John G. Farney

## ADDRESS

Aberdeen

## DATE

Nov 18-55

100% CERTIFICATE OF DEATH

BUREAU V. S.

NOV. 21 1955

REGELY ED  
1955. B. 21.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10893 CERTIFICATE OF DEATH

10912

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Maryland COUNTY Hartford	
24		Hartford Hardeyde Grace		32		Bel Air Bel Air	
71 Harkford Memorial Hospital				1. Harkford			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
Baby		Boy		Thompson		November 26 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Male	White	Newborn	11/25/55	23 hours	Months	Days	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Milton Hubert Thompson				Katherine Pickle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS			
762-5				Hosp records.			
18. MEDICAL CERTIFICATION							
IMMEDIATE CAUSE (A) RESPIRATORY FAILURE							
ANTECEDENT CAUSE(S) DUE TO (B) ATELECTASIS AND/OR HEMALINE MEMBRANE							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) EXTREME PREMATURITY (BIRTH WT 2'9")							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. SIGNATURE <i>B.B. Nomineur</i> M.D. ADDRESS (Street, city, town, state) <i>Karen Grace</i> DATE SIGNED <i>11-26-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORI		LOCATION (City, town, or county)	
BURIAL		Nov. 27/55		MT. OLIVE CEMETERY		FAWATWp. YORK Co. PA.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Nov. 27-55		G. S. Lewis m.d.		John H. Harkins Delta Pa.			

81 BROADWAY - NEW YORK 3-6944 - STATE STREET

THE GOVERNORATE OF DAKH

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BUREAU V. S.

NOV 30 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10914

## 10894 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Havre de Grace 24 (If rural give location)			
24 Havre de Grace	1 Month	Havre de Grace	Havre de Grace Heights			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH				
(First) Benjamin	(Middle) C	(Lost) Wales	(Month) Nov.	(Day) 17	(Year) 1955	
5. SEX Male	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug 29 1878	9. AGE last birthday 95 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	11. BIRTHPLACE (State or foreign country) N.Y. Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John J. Wales		14. MOTHER'S MAIDEN NAME Mount Pleasant				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 40-12-3456		17. INFORMANT & ADDRESS John J. Wales, 3328		
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 3328		19. MEDICAL CERTIFICATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
IMMEDIATE CAUSE (A)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days		
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)		Cerebral Arterioclerosis				
DUE TO DUE TO (C)		generalized Arterosclerosis				
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work		21f. HOW DID INJURY OCCUR?
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				Not while at work		
21g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						
22. I hereby certify that I attended the deceased from <u>Aug. 11, 1955</u> to <u>Nov. 17, 1955</u> that I last saw the deceased alive on <u>Nov. 17, 1955</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>John J. Madison, M.D.</u> ADDRESS (Street, city, town, state) <u>Mount Pleasant, Havre de Grace, Md.</u> DATE SIGNED <u>11/17/55</u>						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 19, 1955		NAME OF CEMETERY OR CREMATORIAL Havre de Grace		LOCATION (City, town, or county) Md.
24. REC'D BY REGISTRAR DATE Nov. 19-1955 G. T. Dennis & H. Brody, Mort. Service Pa		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS

WEALTHY STATE RESERVE CO. OF NEW YORK

STATE CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE
EDWARD R. HARRIS	50	Male	NOV 21 1955
ADDRESS	STREET	CITY	STATE
1000 BROADWAY	NEW YORK	NEW YORK	NEW YORK
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME	NAME OF CEMETERY
DR. J. H. HARRIS	NEW YORK HOSPITAL	NEW YORK CEMETERY	NEW YORK
NAME OF ATTORNEY	NAME OF NOTARY	NAME OF CLERK	NAME OF JUDGE
EDWARD R. HARRIS	EDWARD R. HARRIS	EDWARD R. HARRIS	EDWARD R. HARRIS

RECEIVED  
NOV 21 1955  
BUREAU U. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10895 CERTIFICATE OF DEATH

10915

Reg. Dist. No. 185-

## 1. PLACE OF DEATH

COUNTY Harford MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Havre de Grace LENGTH OF STAY  
 (In this place)  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 847 Erie Street

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Havre de Grace STREET  
 ADDRESS 847 Erie Street (If rural give location)

3. NAME OF  
 DECEASED  
 (Type or Print)

(First) Mary (Middle) V. (Last) Williams

4. DATE (Month) (Day) (Year)  
 OF DEATH 11 - 25 1955

## 5. SEX

Female Negro

6. COLOR OR  
 RACE

7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) Married

## 8. DATE OF BIRTH

5-10-1871

9. AGE last birthday  
 84 yrs.

IF UNDER 1 YEAR  
 Months 0 Dey 0 Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired) Housewife

10b. KIND OF BUSINESS  
 OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Baltimore County, Md.

12. CITIZEN OF WHAT  
 COUNTRY? U.S.A.

## 13. FATHER'S NAME

John Scion

## 14. MOTHER'S MAIDEN NAME

Sarah E. Johnson

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) no (If Yes, give war or dates of service) no

## 16. SOCIAL SECURITY NO.

Mr. Joshua E. Williams - Haven De

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) Uremia

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Hypertensive Cardiovascular disease

INTERVAL BETWEEN  
 ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO

21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

2fc. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
 M.  White  Not white  
 at work  at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/24, 1955, to 11/24, 1955, that I last saw the deceased  
 alive on 11/24, 1955, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

SIGNATURE

George J. Stansbury M.D. 569 Revolution St. Havre de Grace, Md. 11/26/55

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY) DATE THEREOF NAME OF CEMETERY OR CREMATORIAL  
Burial 11-28-55 Union Methodist Cemetery LOCATION (City, town, or county)  
Aberdeen (State) Md.

24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
G. L. Lewis m.d. Otelia J. Bullock-Havre de Grace, Md.

DATE Nov 27-1955

• 1000 例中医治疗学

**U. S. BUREAU**

584 *Sei-ichi*

RECEIVED